U.S. Army NAF Employee Benefits Program

Group Life Insurance

Summary Plan Description

Effective 1 January 2001

2001 USANAF GROUP LIFE INSURANCE PROGRAM
SUMMARY PLAN DESCRIPTION
IMPORTANT

This booklet provides a brief description of the Army Medical Life Group Insurance plan for active and retired nonappropriated fund (NAF) employees of the United States Army. While every effort has been made to describe the plan completely and accurately, this booklet cannot contain a full restatement of all terms and provisions of the plan. If any conflict exists between the booklet and plan document, the terms of the plan document governs.

FOREWORD

This booklet contains valuable information about the following benefits available to you under the Army Nonappropriated Fund (NAF)

Group Life Insurance Plan

This booklet is a summary description, as of 1 January 2001, of the main provisions of:

The Army NAF Group Life Insurance Plan

Not every limitation or detail of the plan is included in this booklet.

The official documents for the Army NAF Group Life Plan control all aspects of basic benefits and disputes. The plan document governs in deciding benefits and also in the event this booklet does not agree with the actual provisions of the plan.

This booklet is intended for Army NAF employees who are considering participation in the employee benefits program, for participants and for survivors or beneficiaries of participants.

HOW TO USE THIS BOOKLET

This booklet is your guide to the Army NAF group life insurance plan. (Another booklet on the retirement program and the 401(k) savings plan is available for download at www.NAFbenefits.com.)

In order to help you get the most from your benefits program, this booklet:

- Describes the coverages available to you under the basic life insurance plan and optional life insurance plan.

This material is written in non-legal language for easy reference. This booklet is organized by real-life events to help you find the answers to specific questions. These events are the times you are most likely to need information on the plan.

Refer to the TABLE OF CONTENTS to find the section that deals with your situation to get answers to your questions.

While this booklet is designed for quick reference when you most need information about the plans, the best thing to do is to look it over in advance, think of questions you have, and practice finding the answers.

If this booklet does not answer your question or you need more information, first contact your civilian personnel office (CPO). If you need more help, call the Employee Benefits Office. Phone numbers are listed at **www.NAFbenefits.com**

Overseas employees may contact the Employee Benefits Office or the claims office at the appropriate toll-free number shown at **www.NAFbenefits.com.**

After you are familiar with this booklet, put it with your important papers; that way you or members of your family will be able to find it when you need information about the plans.

Table of Contents

INTRODUCING YOUR BENEFITS PROGRAM

The best way to be sure you have the coverage you need to meet emergencies is to have the protection of a sound benefits program. Your Army NAF Employee Benefits Program gives you that protection by offering you the opportunity to participate in the health insurance program, the life insurance program, the 40l(k) savings plan, and/or the retirement plan. (The medical, savings and retirement plans are described in other booklets.) You may participate in all of these programs or some of them. Your benefits program permits you to tailor your participation to your needs.

The Army Medical Life Fund (AMLF) was established in 1966 to offer eligible NAF employees the opportunity to participate in health and life insurance programs. The AMLF contracts with a claims service company to administer the AMLF which includes life insurance and a managed care type of medical insurance (referred to as the AMLF medical plan) together with dental insurance if you wish.

HMOs are available to NAF employees in a limited number of geographic areas only. The HMOs are not a part of AMLF; but they are a part of your health insurance program.

The life insurance plan offers basic life insurance and, if you wish more coverage, optional life insurance.

The retirement plan and the 401(k) savings plan are described in another booklet which is available for download from www.NAFbenefits.com

WHO'S WHO IN YOUR LIFE INSURANCE PROGRAM

Your civilian personnel office can give you a great deal of information and most of the forms you need for the benefits program.

The Benefits Program Manager of the U.S. Army Nonappropriated Fund Employee Benefits Office administers the employee benefits program in the exclusive interest of participants. The Benefits Program Manager is responsible for establishing and maintaining the records of the plans, calculating and authorizing benefit payments, resolving questions, considering appeals, and making rules to assure the programs are administered fairly.

The various health maintenance organizations administer their own plans.

Your group life insurance program is insured by Unicare Inc.

YOUR LIFE AND ACCIDENT INSURANCE PLANS

The life insurance plans are a part of the Army Medical Life Fund and are administered by Unicare.

Each of us has different life insurance needs. Your benefits program offers you a choice of life insurance protection. Whether you are a single person working at your first job, a new parent concerned about your family's future security, or an older parent with grown children, you can feel secure knowing you have the protection that meets your needs.

Coverage is provided through your:

- Basic life insurance plan which includes:
  - Basic life insurance for you.
  - Accidental death and dismemberment insurance for you.
  - Life insurance for your dependents.
- Optional life insurance plan.

Your life insurance plans pay benefits to your beneficiary(ies) in case of your death (basic and optional life insurance) or to you if a covered family member dies (dependent life insurance).

Your accidental death and dismemberment plan pays a benefit to your beneficiary if you die as the result of a non-work related accident, or to you if you lose sight or limb as the result of such an accident. (Work related accidents may be covered by Workers' Compensation.)

You choose the amount of your insurance coverage when you enroll. Briefly, you may have:

- Basic life insurance at 1 or 2 times your basic annual salary up to $250,000. (See the definition of Basic Annual Salary on **page 4**.)

Employees enrolled in the basic life insurance plan also receive:

- Accidental death and dismemberment insurance in the same amount as the basic life insurance coverage.
- Dependent life insurance at $5,000 for a spouse and $2,500 for each child who qualifies as a dependent child under the plan. (**Dependents** are defined on **page 5** .)

♦ Optional life insurance in multiples of $10,000 up to two times your basic life insurance amount, or $500,000, whichever is less.

WHEN YOU JOIN THE LIFE INSURANCE PROGRAM

WHO CAN ENROLL FOR LIFE INSURANCE

You can enroll in the life insurance program if you are in an eligible class. You are in an eligible class if you are:

♦ A regular NAF employee working at least 20 hours a week; AND

♦ Working in one of the 50 United States, the District of Columbia, or Puerto Rico.

HOWEVER, if you are working overseas, you must be a U.S. citizen or the spouse or child of a U.S. citizen.

(Employees of the Army-Air Force Exchange Service, "leased employees," and off duty military personnel **may not** participate in the life insurance plan. Eligible employees of the federal government, participating in the USANAF Retirement/401(K) Savings Plans IAW P.L. 101-508 or P.L. 104-106, are not eligible to participate in this program.)

WHEN TO ENROLL

You may enroll:

♦ Within 31 days after you start work as a regular, nonappropriated fund (NAF) employee or, if you are a NAF employee who is not now in an eligible class, within 31 days from the date you meet the requirements to be in an eligible class.

♦ At any other time if you provide evidence of good health (see below).

♦ During an open enrollment period or (open season) when anyone may enroll in the **basic** life insurance program. (Evidence of good health is required for **optional** life insurance in excess of $250,000 or any time after the initial 31-day eligibility period.)

ENROLLMENT WITH EVIDENCE OF GOOD HEALTH

To enroll for basic life insurance or optional life insurance with evidence of good health, refer to the Statement of Health form at **Appendix A-3**. If you can answer "no" to both questions, complete the form and send it to the Employee Benefits Office at P.O. Box 107, Arlington, VA 22210-0107.

If you answer "yes" to either question, do not submit this form. Instead, you must complete and submit an Application for Evidence of Insurability (Form 61G) which is available from your CPO or **Appendix A-3**. Send the completed form to the Employee Benefits Office at the address on the back cover of this booklet. If your application is approved, you may obtain coverage according to the limits of the plan by completing DA Form 3473 which you may obtain from your CPO. Your coverage will be effective in accordance with **Army Regulation 215-3**.

BEFORE YOU ENROLL

Before enrolling in the life insurance program, you must decide on the kinds and amounts of coverage you want. The following are the choices available to you. (Also look at the Summary of Life Insurance Benefits at **Appendix A-1.**)

BASIC LIFE INSURANCE PLAN

The basic life insurance plan will pay the amount of your coverage (your life insurance benefit) to your beneficiary in the event of your death. Your beneficiary is the person or persons you name to receive your life insurance benefits if you die.

You have a choice between these benefit amounts:

- An amount equal to your basic annual pay (minimum coverage $6,000, maximum coverage $250,000). This is referred to as 1 x basic annual pay in this booklet.

- An amount equal to 2 times your basic annual pay (minimum coverage $10,000, maximum coverage $250,000). This is referred to as 2 x basic annual pay in this booklet.

If the amount of your salary is not an even multiple of $1,000, the amount of your benefit will be rounded up to the next even $1,000 level. For example, if your basic annual pay is $14,200 and you choose a benefit of 1 x your basic annual pay, your benefit under the plan would be $15,000.

Basic Annual Salary

Your basic annual salary is the basic rate of pay defined in **Army Regulation 215-3** multiplied by the number of hours you are assigned to work per week in your position (shown on DA Form 3434, Notification of Personnel Action), multiplied by 52 weeks.

If you are appointed to a regular full-time position, it is assumed you have a 40-hour work week. If you are appointed to a part-time position, it is assumed you have a 20-hour work week, unless the DA Form 3434 states otherwise.

Assuming the hourly basic rate of pay to be $7.96, here are two examples:

- **Regular Full-time Employee** - $7.96 is the hourly basic rate of pay MULTIPLIED BY 40 hours per week MULTIPLIED BY 52 weeks per year EQUALS $16,556.80 basic annual salary. (Your coverage in this case would be rounded up to $17,000 FOR 1 times basic salary. For 2 times basic salary, multiply $16,556.80 times 2 = $33,113.60 or $34,000 insurance.)

  ($7.96 x 40 x 52 = $16,556.80)

- **Regular Part-time Employee** - $7.96 is the hourly basic rate of pay MULTIPLIED BY 20 hours per week MULTIPLIED BY 52 weeks per year EQUALS $8,278.40 basic annual salary. (Your coverage in this case would be rounded up to $9,000 for 1 times basic salary. For 2 times basic salary, multiply $8,278.40 times 2 = $16,556.80 or $17,000 insurance.)

  ($7.96 x 20 x 52 = $8,278.40)

ACCIDENTAL DEATH AND DISMEMBERMENT PLAN

If you choose basic life insurance, you will automatically be enrolled for accidental death and dismemberment insurance at no additional cost to you. This plan pays a benefit to you if you are severely injured in a non-work related accident or to your beneficiary if you die as the result of such an accident. The amount of your coverage will be the same amount as your basic life insurance coverage. You or your beneficiary will be paid the full benefit amount as stated in the Summary of Life Insurance Benefits at **Appendix A-1**.

This plan does not apply if accidental death or dismemberment is work related. In that case Workers' Compensation may apply. (See **Army Regulation 215-1**.)

DEPENDENT LIFE INSURANCE PLAN

If you choose basic life insurance and you have family members (husband, wife or children), you will automatically be enrolled for dependent life insurance at no additional cost to you. You are automatically the beneficiary of this benefit. You will be paid these benefits in the event of death of one or more of your family members:

- $5,000 for your husband or wife.
- $2,500 for each child.

The Plan will not consider a dependent life insurance claim unless the family member died while you were covered by the basic life insurance plan. Family members must qualify as dependents to be covered.

Dependents are defined as:

- Your husband or wife if not divorced or legally separated from you.

- Unmarried children (including stepchildren and foster children) up to age 19 who depend on you for support and are not working on a regular, full-time basis.

- Unmarried children (including stepchildren and foster children) up to age 23 who are in school, depend on you for support and are not working on a regular, full-time basis.

Effective 1 Jan 01, additional dependent life insurance was added to the program. Eligibility applies the same as for basic life insurance. In addition to the free dependent life insurance for dependent spouses of $5,000 and $2,500 for each dependent child, employees may now elect up to 5 times the amount of free dependent life insurance. Premium for levels 2-5 is fully paid for by the employee. Here are the coverage(s) and rates for calendar year 2001.

Increment	Spouse	Dependent	Biweekly cost
1	$5,000	$2,500	None
2	$10,000	$5,000	$2.35
3	$15,000	$10,000	$4.70
4	$20,000	$15,000	$7.05
5	$25,000	$12,500	$9.40

The rate includes spouse and all eligible children. The employee must be enrolled in the basic life insurance plan to elect additional optioinal dependent life insurance coverage.

Note: an employee must have worked one full day on or after the effective date of the election, in order for benefits to be payable to the beneficiary of record.

OPTIONAL LIFE INSURANCE PLAN

If you choose basic life insurance, you may also choose optional life insurance. Optional life insurance provides additional financial security for your family in the event of your death. You can choose a benefit amount (in multiples of $10,000) of up to two times the amount of your basic life insurance benefit or $500,000, whichever is less.

If you do not choose optional life insurance at the time you are hired or within 31 days from the date you meet the requirements to be in an eligible class or you elect an amount of optional life insurance in excess of $250,000, you must get approval by completing and submitting either the Statement of Health form at the back of this booklet or an Application for Evidence of Insurability (Form 61G).

If your application is approved, you may obtain coverage according to the limits of the plan by completing DA Form 3473. (This form is available from your CPO.) Your coverage will be effective in accordance with **Army Regulation 215-3**. Of course, you may reduce or cancel your optional life insurance at any time without prior approval.

COST OF LIFE INSURANCE

Basic Life Insurance

This plan costs 12 cents for each $1,000 of coverage each pay period. For example, if your salary is $14,200 and you choose basic life insurance of:

- 1 x your basic annual pay, your coverage would be rounded up to the next even thousand or $15,000. Your cost for this $15,000 of coverage would be $.12 x 15 or $1.80 each bi-weekly pay period.

- 2 x your basic annual pay, you would multiply $14,200 x 2 = $28,400, and round it to $29,000 of coverage. Multiply $.12 x 29 and the cost would be $3.48 each bi-weekly pay period.

Optional Life Insurance

The cost of optional life insurance is based on the amount of coverage you take and your age. Optional coverage is available only in multiples of $10,000. The amount of optional coverage you may take is limited to the smaller of 2 x your basic coverage OR $500,000.

The biweekly cost of each $10,000 of optional life insurance is:

Employee's Age	Biweekly Cost
Under 35	$ .60
35 to 39	.70
40 to 44	1.20
45 to 49	1.80
50 to 54	3.00
55 to 59	4.60
60 to 64	7.60
65 to 69	10.60
70 and older	17.40

For example, if you choose to purchase $50,000 of optional life insurance and you are 46 years old, your biweekly cost will be 5 x $1.80 = $9.00.

A chart with premium costs is also available under the Life Insurance Section at www.NAFbenefits.com

HOW TO ENROLL

To enroll in the life insurance program you must fill out DA Form 3473, Part II. These forms are available from your civilian personnel office. After your enrollment form is processed, you will see a deduction for life insurance on your Earnings and Leave Statement. This applies to employees who get paychecks from NAF Financial Services in Texarkana, Texas.

- Enter the appropriate enrollment code from **Appendix A-2** for the coverage you want in Block 16 of DA Form 3473 (Pt II).

- Fill out the rest of the form and sign it. Make sure the following items are correct:

  - Life insurance enrollment code
  - Beneficiary

If you wish to enroll in the health insurance program or in the retirement plan, you may do so on the same DA Form 3473, Pt II you fill out for life insurance.

NAMING YOUR BENEFICIARY

Usually, your beneficiary is a family member or close friend. As explained earlier, in the case of dependent life insurance, you are your dependents' beneficiary.

You name your beneficiary on DA Form 3473, Pt II which is available from your CPO. You can change your beneficiary at any time by filling out another DA Form 3473, Pt II and giving it to your CPO. When you change your beneficiary, the change cancels all earlier beneficiaries. Do not confuse your life insurance beneficiary on DA Form 3473, Pt II with your beneficiary for unpaid compensation on DA Form 5521-R.

Appendix A-5 gives suggested wording for designating beneficiaries.

You do not need your beneficiary's permission to change your designation. If you die and plan records list two or more beneficiaries, the benefit will be divided equally among them, unless the records contain a written request from you for a different arrangement.

If you have not listed a beneficiary or if your beneficiary dies before you do, the benefit will be paid to your estate or to any one or more of these surviving relatives: your wife, husband, child or children, mother, father, brothers or sisters.

If your beneficiary is a minor (not yet age 18) or for some other reason is unable to accept the responsibility of being a beneficiary, benefits may be paid to your beneficiary's closest living relative or to whomever has temporary custody and support until a permanent guardian is appointed. Benefit payments will not be more than $50 per month.

WHEN COVERAGE WILL BEGIN

Your life insurance coverage will begin the date you enroll. You must also work one full day after your insurance becomes effective. ***(for example, if your election for life insurance was during open season of 2000, then it will not become effective until the first day that you work following January 1st, 2001)***. Deductions from your paycheck to pay your share of the cost of your coverage (your premium payments) will begin on the first day of the first full payperiod, on or after election (Except open season elections premiums begin on the first full payperiod in the new calendar year).

WHEN THERE IS A DEATH

If you die while covered under these plans, your life insurance and accidental death and dismemberment insurance benefits will be paid to your beneficiary. Benefits can be paid in one amount, or you can choose to have them paid in installments under a special arrangement with Unicare, our life insurance company. If you die without making such an arrangement, your beneficiary may do so.

If a family member dies while covered under the dependent life insurance plan, benefits will be paid to you.

FILING A CLAIM

In order to receive benefits, you (or your beneficiary) must file a claim within 90 days after the death occurs. The beneficiary must write to the NAF Employee Benefits Office and enclose a certified copy of the death certificate. The address is P.O. Box 107, Arlington, VA 22210-0107.

If the death was accidental, a police report, newspaper clipping or other proof of a non-work related accidental death will be required as well as the certified copy of the death certificate. If an accidental death is work related, it may be covered by Workers' Compensation (see **Army Regulation 215-1**). Your CPO can provide assistance.

WHEN THERE IS AN ACCIDENT

If you lose the sight of an eye or lose a limb as the result of a non-work related accident and the loss occurs within 365 days after such an accident, your accidental death and dismemberment plan will pay you a benefit. The full benefit is the same amount as your basic life insurance coverage.

The full amount of the benefit will be paid if you die as the result of a non-work related accident or for any of the following losses:

- Both hands.
- Both feet.
- One hand and one foot.
- Sight of both eyes.
- One hand and sight of one eye.
- One foot and sight of one eye.

Half the amount of the benefit will be paid for any of these losses:

- One hand.
- One foot.
- Sight of one eye.

For you to qualify to receive benefits, hands or feet must be severed at or above the wrist or ankle joint. Loss of sight means a total loss of sight without any possibility of recovery.

The plan will not pay more than one full benefit amount per accident, no matter how severe the injuries. Also the plan will not pay benefits for losses caused by:

- Disease.
- Physical or mental infirmity.
- Medical or surgical treatment.
- Ptomaine.
- Bacterial infections, except infection through a visible wound suffered in an accident.
- Suicide while sane or insane.
- Intentionally self-inflicted injury.
- War or any act of war, declared or undeclared.

FILING A CLAIM

A claim for any loss covered by your accidental death and dismemberment plan should be filed within 90 days after the loss occurs. Contact the NAF Employee Benefits Office at the address or phone number shown at **www.NAFbenefits.com**. In case of non-work related accidental death, your beneficiary will be paid the benefit. If you lose sight or limb, benefits will be paid to you.

IF YOU BECOME DISABLED

If you become totally disabled on or after January 1, 1988, while covered under the basic life insurance plan, your employer will continue your coverage without requiring you to make premium payments, even if the plan ends. (In other words, your premiums will be waived.) Totally disabled means you are disabled to such an extent you cannot work for pay or profit or participate in any business or occupation.

To qualify:

- You must have been covered by the plan for at least 5 consecutive years before you were disabled;
- The disability must occur before you turn age 62

You must provide proof of your disability to the Employee Benefits Office at the address shown at **www.NAFbenefits.com**. To provide proof of your disability, complete EBB Form 766R (a reproducible copy is at **Appendix A-6**) from your civilian personnel office or the Employee Benefits Office, complete the form, and return the form to the office which furnished it to you. A determination on your disability will be made by the Office of The Surgeon General or any other qualified medical person designated by the Benefits Program Manager and you will be notified of that determination.

You must provide proof of your disability no later than 12 months after your last day of work and for every 12-month period thereafter. As part of your proof you may be asked to have a physical examination which will be paid for by the Army Medical Life Fund.

If your disability ends before age 62 or you fail at any point to provide proof of your disability, your waiver of premium will be discontinued. If you are also receiving a monthly disability annuity through

the USANAF Retirement Plan, it will also be discontinued until you are eligible for a normal retirement benefit at age 62. If you do not meet normal retirement eligibility, you will not be eligible to continue to receive a monthly annuity at any time after your disability annuity is discontinued.

When you become age 62 and you are receiving a monthly annuity, your life insurance amount will reduce to the lowest amount of coverage you had during the 5 years just before your disability retirement. This amount will further reduce 2% per month when you turn age 65. However, it will never be less than 25% of the lowest amount of coverage you had during the 5 years prior to your retirement.

If you do not return to work within 31 days after your disability ends, you may convert your group life insurance to an individual life insurance policy. See **CONVERTING LIFE INSURANCE COVERAGE** for additional information.

IF YOU DIE DURING RETIREMENT

The retiree life plan includes basic life insurance and, under certain conditions, optional life insurance. However, accidental death and dismemberment and dependent life coverage are not provided after separation from employment for retirement.

BASIC RETIREE LIFE COVERAGE

If you retire (elect a normal, early or disability annuity) on or after 1 January 1988 and you have been covered by the basic life plan for 15 years (total) or for the 5 years just before your retirement, your basic retiree life benefit is:

- The lowest amount of coverage you had during the 5 years just before your retirement.

Basic retiree life benefits are provided at no cost to you.

Benefit Reductions

The amount of your basic retiree life benefit will be reduced 2% each month beginning when you turn age 65. However, it will never be less than 25% of the lowest amount of coverage you had during the 5 years before your retirement. If you continue working after age 65, you will continue to be covered with your elected amount as an active employee until you retire. At that time, benefits will be reduced for each month since you turned 65.

Optional Retiree Life Coverage

You may continue optional life coverage when you retire if you have had optional life coverage for at least 15 years or you have been covered for the 5 years just before your retirement. You can continue up to the lowest amount of coverage you had during the 5 years just before your retirement.

If you continue optional life coverage, you must pay the full cost of your coverage until age 65. After age 65, coverage will be provided at no cost to you. Beginning at age 65, the amount of the benefit will be reduced 2% each month for 50 months, at which time this coverage will end. (A request for retiree optional life insurance coverage is at **Appendix A-7**.)

CONVERTING LIFE COVERAGE AT RETIREMENT

If you retire at age 65 and your benefit is reduced, you may convert the part of your coverage that is reduced to an individual nongroup policy. The rest of your basic coverage (and optional coverage if you have it) will continue. See **Converting Life Insurance Coverage** on **page 11**. You may also contact your CPO or the Employee Benefits Office at the address shown on the back cover of this booklet for additional information.

WHEN COVERAGE ENDS

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Your coverage for life insurance and for accidental death and dismemberment will end when:

- Your employment ends.
- Your employment status changes so you are no longer in an eligible class (see **WHO CAN ENROLL FOR LIFE INSURANCE** on **page 2**).
- You request that your coverage be canceled or you stop making plan contributions.
- You begin active duty in the armed forces of any country, state or international organization.
- The policy under which coverage is provided ends.

Special Cases

Your life insurance and accidental death and dismemberment coverage will continue after your employment ends under the following circumstances:

- If your employment ends because of illness, non-job-related injury, or pregnancy, coverage may continue for 1 year.
- If your employment ends because you are on approved leave without pay (LWOP), life coverage (but not accidental death and dismemberment) will continue for 1 year, provided you and your employer continue to make premium payments.
- If your employment ends because you retire, life coverage **(but not accidental death and dismemberment and dependent life insurance)** will continue indefinitely, subject to age reductions.

DEPENDENT LIFE

Your dependent life coverage will end when:

- All your life insurance coverage ends.
- Your family member no longer qualifies as a family member (see the definition of dependents on **page 5**).
- Your family member begins active duty in the armed forces of any country, state or international organization.
- The active employee coverage ends.

WHEN LIFE COVERAGE CONTINUES

BASIC RETIREE LIFE COVERAGE

If you retire on or after 1 January 1988, are receiving an immediate,early or disability annuity only, and have been covered by the basic life insurance plan for 15 years or for the 5 years just before your retirement, your basic retiree life benefit (provided at no cost to you) is the lowest amount of coverage you had during the 5 years just before your retirement.

Benefit Reductions

The amount of your basic retiree life benefit is reduced 2% per month beginning at age 65. However, it will never be less than 25% of the lowest amount of coverage you had during the 5 years before your retirement. If you continue working after age 65, you will continue to be covered as an active employee until you retire. At that time, benefits will be reduced for each month since you turned age 65.

OPTIONAL RETIREE LIFE COVERAGE

You may continue optional life coverage when you retire if you have had optional life coverage as an active employee for at least 15 years (total) or you have been covered for the 5 years just before your retirement.

You may continue up to the lowest amount of coverage you had during the 5 years just before your retirement.

If you continue optional life coverage, you must pay the full cost of your coverage until age 65. After age 65, coverage will be provided at no cost to you.

Beginning at age 65, the amount of the benefit will be reduced 2% each month for 50 months, at which time this coverage will end.

(See Summary of Life Insurance Benefits at **Appendix A-1**.)

WHEN YOU STOP WORK AS A NAF EMPLOYEE

If you stop working as a NAF employee, your life insurance benefits end the last day of the last full bi-weekly pay period before the date you end your employment. However, in the following situations, you may either extend your life insurance coverage or convert to a personal plan:

- If you are on approved leave without pay (LWOP), your coverage may be extended for up to 1 year, provided you and your employer continue to make premium payments.

- If you retire, the length of your extension varies depending on the circumstances. See WHEN LIFE COVERAGE CONTINUES on **page 10** for eligibility requirements.

CONVERTING LIFE INSURANCE COVERAGE

You may convert your group life coverage (except for accidental death and dismemberment and dependent life insurance) to an individual nongroup policy for any of these reasons:

- Your employment ends.
- Your employment status changes so you are no longer eligible for life coverage.
- The plan ends (but only if you have had life coverage for the 5 years before the plan ends).
- You retire.

Amount of the Benefit

The amount of the benefit under your individual nongroup policy depends on the reason your life coverage ends.

- If your coverage ends because your employment ends or because you are no longer in an eligible class, you can choose an amount up to the amount you had under the group plan.

- If your coverage ends because the plan ends, the benefit is whichever of the following amounts **is less**:

- Up to the amount you had under the group plan minus the amount of any new life coverage for which you become eligible within 31 days;
  or
- $2,000.00

  When you retire and your life benefits are reduced, you can choose an amount up to the difference between the amount you had before the reduction and the amount that is continued as part of your annuitant retiree coverage.

Time is critical in converting your group life insurance coverage to an individual nongroup policy.

To receive an application to convert your coverage and **information on your premiums**, use the form at **Appendix A-4**. Because of the short time allowed to convert your coverage, you should **request the application before your coverage actually ends**. Please do not do so, however, until you have a firm termination date.

The John Hancock Office must receive your application to convert your life insurance coverage to an individual nongroup policy AND your first premium payment in sufficient time to assure receipt by the policy underwriter not later than 31 days after your coverage ends. It is recommended that this form is completed and sent to the John Hancock Office before separation of employment.

Your individual nongroup policy becomes effective after the 31-day conversion period. If you die during this period, whether you applied for conversion or not, your beneficiary will receive the maximum benefit for which you could have applied.

LIVING BENEFITS

The living benefit allows you to receive a portion of your life insurance benefits if you become terminally ill. The accessibility of a portion of your life insurance benefits while you are still living can help you meet financial obligations while you are terminally ill. In order to be eligible for living benefits, you must have participated in the basic life insurance plan for the 5 year period immediately preceding your diagnosis of terminal illness and your doctor must diagnose you to have less than one year to live. If you are age 62 or older and retire, you must meet the aforementioned participation rules and draw an immediate or disability annuity. Have your CPO contact the Employee Benefits Office if you think you may be eligible for this benefit.

CONTROL PLUS ACCOUNT

The guaranteed access account program is a payment method that allows your beneficiaries to take the time necessary to make important financial planning decisions without worrying about the safety of the life insurance proceeds, lost interest earnings or deadlines. Under this program, upon your death, John Hancock automatically establishes an account for each of your beneficiaries whose proceeds are more than $10,000. (If the proceeds are less than $10,000 then payment is made in a single check.) The beneficiary receives a checkbook which he or she can use to draw upon the account, the money in the account earns a competitive rate of interest.

Summary of Life Insurance Benefits
Active Employees Only

	Amount of Coverage	Minimum	Maximum
Basic Life	A. 1 times basic annual salary (rounded to next even $1,000)	$6,000.00	$250,000.00
	OR		
	B. 2 times basic annual salary (after multiplying basic annual salary by 2, round the answer up to the next even $1,000)	$10,000.00	$250.000.00

Optional	Up to 2 times basic life election, in Multiples of $10,000, round down to The next even $10,000	$10,000.00	$500,000.00

Dependent Life	$5,000 for spouse, $2,500 for dependent child

Accidental Death and Dismemberment	Full amount of Basic Life for the below losses:	One half of Basic Life for the following losses:
	Life	One Hand
	Both Hands	One Foot
	One Hand & One Foot	Sight of One Eye
	Sight of Both Eyes	
	One Hand and Sight of One Eye	
	One Foot and Sight of One Eye	

The plan will not pay more than the full amount of Basic Life insurance coverage per accident, no matter how severe the injuries. Loss must be the result of an injury and not natural causes.

Basic Retiree Life Insurance
Retired Employees Only

This coverage is available only to retirees receiving a monthly pension (annuity) check

Conditions	Amount of Insurance
Retiree participated in the group life plan for the 5 year period immediately preceding retirement and elects a monthly annuity. (not available to retirees electing a deferred annuity, money on deposit or a refund of contributions and interest.	Lowest amount of basic insurance in effect for the 5 year period immediately preceding retirement. This coverage is provided free of charge. Coverage will never reduce below 25% of the original continued amount.
OR	
Retiree participated in the Group Life Plan for the year Immediately preceding retirement but less than the 5 Year period preceding retirement and elects a monthly Annuity. (Not available to retirees electing a deferred Annuity, money on deposit or refund of contributions)	$2000.00

Optional Retiree Life Insurance

Retiree participated in the Group Life Plan for the 5 year Period immediately preceding retirement & elects an annuity	Lowest amount of optional insurance in effect for the 5 year period immediately preceding retirement. retiree pays premium monthly until age 65. after age 65, the coverage is free, but it reduces 2% per month until it is exhausted after 50 months.

Appendix A-2

Enrollment Codes Group Life Insurance Plan

	Election	Code
No Life Insurance	Declines participation	ØOO
Basic Life Insurance	1 times basic annual salary	AOOO
	2 times basic annual salary	BOOO

Basic Life Insurance plus Optional Life Insurance Codes		
One times basic annual salary plus	Optional Life	Two times basic annual salary plus
Code		**Code**
A010	$10,000	B010
A020	$20,000	B020
A030	$30,000	B030
A040	$40,000	B040
A050	$50,000	B050
A060	$60,000	B060
A070	$70,000	B070
A080	$80,000	B080
A090	$90,000	B090
A100	$100,000	B100
A110	$110,000	B110
A120	$120,000	B120
A130	$130,000	B130
A140	$140,000	B140
A150	$150,000	B150
A160	$160,000	B160
A170	$170,000	B170
A180	$180,000	B180
A190	$190,000	B190
A200	$200,000	B200
A210	$210,000	B210
A220	$220,000	B220
A230	$230,000	B230
A240	$240,000	B240
A250	$250,000	B250
...	...	...
...	...	...
...	...	...
A500	$500,000	B500

Appendix A-3

Army NAF Group Life Plan
Statement of Health
(Evidence of Insurability)

Form is to be completed by employee only.

Employee's Name (Please type)

Last First MI

Date of Birth (Please type) Social Security Number Employing NAFI

Answer the following questions truthfully.

1. During the past 5 years, have you been hospitalized or consulted a physician or physicians for any reason, other than "routine physical" examinations?
2. Have you ever had, consulted or been treated by a physician or practitioner for alcohol or drug abuse, heart or blood disease, chest pain, high blood pressure, stroke, diabetes, tumor, cancer, paralysis, convulsions, genito-urinary disorder, kidney disease, gastrointestinal disease, ulcer, hiatal hernia, respiratory disease, arthritis, back or neck impairment, mental or nervous system disorder?

If you have answered yes to either of the above questions, you must submit **Form 61G** on the next page. This form will be submitted to the group insurance plan underwriter for determination of evidence of insurability.

I hereby apply for the benefits to which I am entitled or to which I may become entitled under the provisions of my Employer's Group Life Insurance Plan, and authorize deductions from earnings for the required premiums due toward the cost of this benefit.

I hereby represent and agree that the foregoing statements, together with any explanations above are, to the best of my knowledge and belief, true and complete statement of fact and not opinion and shall be the basis for the provision of coverage. In the event any of the statements or representations herein are not as stated, I understand the Benefit Plan gives my employer the right to render void, the coverage for which I am making application.

I am applying for consideration for coverage outside of the open season period and after 31 days since I became eligible to participate. Click on the box of the coverage you are applying for. If applying for optional, fill in the appropriate amount.

☐ Basic Life (1 times salary)
☐ Basic Life (2 times salary)
☐ Basic Life plus Optional (1 times salary plus $)
☐ Basic Life plus Optional (2 times salary plus $)

☐ Optional Life Insurance Only $ amount

Name of Employee (Typed) Employing Installation Date of Hire

Signature of Employee Date

APPENDIX A-3 LONG FORM

EVIDENCE OF INSURABILITY

FOR GROUP BASIC LIFE AND OPTIONAL LIFE INSURANCE
ARMY NAF GROUP LIFE INSURANCE PLAN

GROUP #2289

EMPLOYEE LAST NAME	FIRST NAME	MI	DATE OF BIRTH	LBS EMPLOYEE WEIGHT
EMPLOYEE STREET ADDRESS	CITY	STATE	ZIP	FEET INCHES EMPLOYEE HEIGHT

Give full details in space after question, for every "Yes" answer to questions 1-3.

1. Have you:

a. Ever had, consulted, or been treated by a physician or practitioner for: alcohol or drug abuse, heart or blood disease, chest pain, high blood pressure, stroke, diabetes, tumor, cancer, paralysis, convulsions, geitourinary disorder, kidney disease, gastrointestinal disease, ulcer, hiatus hernia, respiratory diseaase, arthritis, back or neck impairment, mental or nervous system disorder? ☐

If answered "yes," state diagnosis here: _____

b. Within the last 5 years, consulted a physician, or been hospitalized, for any reason, other than a routine physical examination? ☐

If answered "yes," state diagnosis here: _____

c. Ever had any surgical operation or had surgery advised but not performed? ☐

If answered "yes," explain here: _____

d. For female applicants, To your knowledge, are you pregnant? ☐

If Yes, what is your expected due date? _____ date of hospitalization? _____

e. Have you ever been diagnosed as having or have you ever been treated for Acquired Immune Deficiency Syndrome or HIV? ☐

I hereby apply to Unicare Inc. for insurance to which I am entitled or to which I may become entitled under the provisions of the group policy or policies issued by Unicare Inc. and authorize deductions from earnings of the required premium toward the cost of the insurance. I hereby represent and agree that the foregoing statements, together with an explanations are, to the best of my knowledge and belief, true and complete, are statements of fact and not opinion and shall be the basis for the issuance of insurance coverage under this policy for myself. In the event any of the statements or representations herein are not as stated, I understand that the group policy gives the insurance company the right to render void the insurance for which I am making application within two years of the date I become insured, or if I should die within said two year period, at any time thereafter. This application shall be deemed to have been declined if it has not been approved by Unicare Inc at its Home Office, within 90 days of the date of this application. No agent, medical examiner, or representative of the Policyholder is authorized to make or discharge contracts, or waive, alter, modify or change any of the provisions of any application or policy or to accept risks or pass on insurability. Notice to or knowledge of any agent, medical examiner, or representative of the Policyholder is not notice to or knowledge of Unicare Inc. If this application is for additional life insurance, I agree the beneficiary shall be the beneficiary of said additional amounts of life insurance. I acknowledge that I have received a copy of this form.

Dated At: ☐

Date Of: ☐

_____
Employee Signature Date

_____
Employing NAFI

_____
Employee Date of Hire

Coverage being applied for:

1 times basic life ☐
2 times basic life ☐
Optional life coverage ☐
Amount of optional life requested $ _____

Return form to: **Employee Benefits Office**
P.O. Box 107
Arlington,VA 22210-0107

EVIDENCE OF INSURABILITY

FOR GROUP BASIC LIFE AND OPTIONAL LIFE INSURANCE
ARMY NAF GROUP LIFE INSURANCE PLAN

MEDICAL EXAMINERS REPORT

To be completed when the amount applied for exceeds $150,000 group life insurance. The medical examiners report may be completed by any legally qualified physician and the fee for this examination is to be paid by the applicant
Physician explain any yes answers to the questions below.

GROUP #2289

EMPLOYEE LAST NAME	FIRST NAME	MI	Apparent Age	General Appearance

Do you find evidence of disease of the respiratory organs,heart or blood vessels? Explain:	Weight	Height	systolic / diastolic Blood Pressure

Do you find any evidence of disease of the stomach or abdominal organs? Explain:	Is there any deformity,impairment of sight or hearing or loss of any part of the body? Explain:

I have today reviewed the answers on Part I of this form, co9mpleted by the applicant, have carefully examined and find said person in sound health and free from all physical defects and infirmities, except as stated. Remarks:

Date	Type physicians name	Signature of Physician

Physicians Address

I authorize any physician, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, or employer having information as to diagnosis, treatment and progrmosis with respect to any physical or mental condition and/or treatment of me and any other information with regards to me to give to Unicare Inc.

I understand the information obtained by use of the authorization will be used by Unicare Inc, or its authorized administrator, to determine eligibility for insurance under the Army NAF Group Life Insurance Plan. Any information obtained will not be released by Unicare Inc. or the Employee Benefits Program adminstrator, to any person or organization except as may be lafully required or as I may further authorize.

I know that I may request a copy of this Authorization.

I agree that a photographic copy of the Authorization shall be as valid as the original and shall be valid for two and one half years from the date below:

Date **Employee Signature**

Return form to: **Employee Benefits Office**
P.O. Box 107
Arlington,VA 22210-0107

NOTICE OF INSURANCE INFORMATION PRACTICES
COLLECTION OF INFORMATION

The information you furnish on your application, including your medical history, is our initial source of information about you and any of your family members proposed for coverage. We also collect information from other sources in an effort to confirm, clarify or supplement the information you supply in evaluating your eligibility.

In seeking more complete medical information, we may ask you to have a physical examination or medical evaluation which often includes special studies such as electrocardiogram, X-ray or laboratory tests. We may also request medical and health information, records and reports from your doctor, other medical care providers or professionals, hospitals, clinics, medical examiners, coroners, and any other medical or medically related facilities or suppliers. The medical and health information collected may include history, physical and laboratory findings, diagnosis, prognosis and treatment related to any past or present physical or mental condition. We also collect information by reviewing our own company records regarding your prior insurance history, including previously collected medical and health information.

DISCLOSURE OF INFORMATION

We treat the information we have gathered about you in a confidential manner, using it in connection with the insurance relationship you have with us. Information in your file may be seen by our administrators, employees, and in certain cases, our legal counsel but only where there is a legitimate need. Personal information about you will not be disclosed without your written authorization. Sometimes, however, we will disclose information about you to third parties without your written consent but only as authorized by law in the following circumstances. With certain health insurance policies, we may disclose information to other insurance companies where there is a possibility of duplicate coverage. We may disclose medical information to your attending physician or treating medical professional to inform you of a medical condition of which you may not be aware. We may disclose information concerning John Hancock applicants to law enforcement authorities and others where required by law. The types of information disclosed will vary depending on the needs of the recipient and the sensitivity of the information. Medical and health information may be disclosed; however, please be assured that information will be disclosed only to the extent reasonably necessary under the particular circumstances and as permitted by law.

FRAUD WARNING

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

ACCESS TO RECORDED PERSONAL INFORMATION

You have the right to obtain personal information we have recorded about you. Within thirty business days after we receive your written request, you will be informed of the nature and substance of such information, the identity of any institutional source which has provided us with the information and be permitted to see, copy or obtain a copy of the information by mail, whichever you prefer.

CORRECTION OF RECORDED PERSONAL INFORMATION

You also have the right to request the correction, amendment or deletion of recorded personal information about you. Within thirty business days after we receive your written request for a correction, amendment or deletion, you will be informed in writing of the acceptance or refusal of your request, including the reason for any refusal.

Any correction, amendment or deletion of recorded personal information will be furnished to persons specifically designated in writing by you who may have received the incorrect or incomplete information within the preceding two years.

If your request is refused you have the right to file a concise statement setting forth what you think is the correct, relevant or fair information and explaining the reasons why you disagree with our refusal. Your statements will be filed with the disputed personal information and become a permanent part of your recorded information in such a way that anyone reviewing the disputed personal information will be made aware of your statements. In any subsequent disclosure, the disputed information will be clearly identified and your statements will be furnished along with the disputed information. Your statements will also be furnished to those who would have received the corrected, amended or deleted information if your request had not been refused.

When contacting us directly to obtain or correct recorded personal information, please direct your inquiries and requests to the address listed below. When contacting us, it is essential that you include your full name, date of birth, address and applicable group policy number.

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY
JOHN HANCOCK PLACE
P.O. BOX 111
CENTRALIZED SERVICES
MEDICAL REVIEW UNIT, B-8
BOSTON, MASSACHUSETTS 02117

We hope that this notice will help you to understand how and why we obtain and use personal information and the ways in which you can learn about this information.

UNICARE®

Request For Group Life Conversion Information

HRMP
Health Reinsurance Management Partnership
Conversion Facility

Instructions

Policyholder (employer): This form should be completed and furnished to every employee who may have the conversion right.

Employee (person requesting information): Complete the employee section and immediately mail to HRMP at the address shown below without delay. (See Section II.)

Section I — To be Completed by Employer

Group Policyholder Or Plan Name:

GROUP NUMBER	PCC	CLAIM BRANCH	or	CASE	GROUP	SUFFIX
22839				ARMYNAF		

EMPLOYEE NAME (LAST, FIRST, MI)	DATE OF BIRTH	CERT. #	SEX	SOC. SECURITY NO.	JOB TITLE
	/ /				

EFFECTIVE DATE OF GROUP COVERAGE	ANN. SALARY	DATE LAST WORKED	EMPL. TERMINATION DATE	INSUR. TERMINATION DATE	SPOUSE DOB
/ /	$	/ /	/ /	/ /	/ /

Coverage Terminating

☐ Employee

Basic Amount	$ _____
Supplemental Amount	$ _____
Other	$ 0
Total Amount	$ _____

Reason for Termination

- ☐ Termination of Employment
- ☐ Termination of Group Policy
- ☐ Reduction of Coverage
- ☐ Retirement
- ☐ Death of Employee
  - Spouse Name: _____
- ☐ Other (Specify): _____

Is Employee/Member on Disability? ☐ Yes ☐ No If "Yes," did he/she become disabled prior to age 60? ☐ Yes ☐ No

Has the insured Member made an Absolute Assignment of the group life insurance to be converted? ☐ Yes ☐ No

If "Yes," please attach a copy of the Absolute Assignment form.

THIS FORM WILL BE ☐ HANDED TO EMPLOYEE ON (DATE) ____/____/____ ☐ MAILED TO EMPLOYEE ON (DATE) ____/____/____

SIGNATURE OF AUTHORIZED EMPLOYEE REPRESENTATIVE	PRINT NAME AND TITLE OF AUTHORIZED REPRESENTATIVE
X	

COMPANY TELEPHONE NUMBER	COMPANY ADDRESS

Section II — To be Completed by Employee

Do not mail this form to HRMP unless the top portion is completed and signed by employer.

Your Group Term Life Insurance Benefits are terminating as indicated above. You may be eligible to convert to an individual life policy. After you promptly send this form to HRMP, HRMP will send you a description of the conversion plan, your premium rates and an application form.

The application and first premium payment must received by HRMP within 31 days of the termination of your life insurance benefits, under your employer's group insurance policy.

IMPORTANT NOTICE: This is not an application for conversion of your group life plan coverage. Receipt of this form and subsquent information does not guarantee your eligibility to convert your group term life insurance.

REQUESTOR'S NAME (LAST, FIRST, MI)	RELATIONSHIP TO EMPLOYEE

HOME ADDRESS (NO. & STREET)	CITY	STATE	ZIP

SIGNATURE OF REQUESTOR	DATE	HOME TELEPHONE NUMBER
X		( )

Do not enclose payment with this form. Send the entire form, when completed, to the address below.

Please mail to: HRMP, Life Conversions
5 Hutchinson Drive
Danvers, MA 01923-3777

Toll free # 800-470-8812
Phone # 978-762-0661
Fax # 978-762-4767

Beneficiary Designation

Suggested Wording

Type of Beneficiary	Suggested Wording
Insured's Estate	Insured's Estate
One Beneficiary	John Doe (relationship), SSN, DOB, Address
Two Beneficiaries Equal Shares	John Doe (relationship) 50%, SSN, DOB, Address Kathy Doe (relationship) 50%, SSN, DOB, Address
Two Beneficiaries Unequal Shares	John Doe (relationship) 75%, SSN, DOB, Address Kathy Doe (relationship) 25%, SSN, DOB, Address
Three or More Beneficiaries	John Doe (relationship) 10%, SSN, DOB, Address Kathy Doe (relationship) 15%, SSN, DOB, Address Fred Doe (relationship) 25%, SSN, DOB, Address Julie Doe (relationship) 50%, SSN, DOB, Address
One primary and one secondary	John Doe (relationship) if living; otherwise Kathy Doe (relationship) SSN, DOB, Address of both beneficiaries.
One primary and two secondary	John Doe (relationship) if living; otherwise Kathy Doe (relationship) And Jane Doe (relationship), equally, or the survivor

Proposed Beneficiaries

Heirs, legal heirs, heir at law, legal descendents, legal representatives of next of kin=Insured's Estate

Church or Organization: I.E. Holy Trinity Church, 222 Maine St, Wash DC 20002 or American Legion Post, include IRS TAXID #a nd address.

APPENDIX A-6

U.S. Army Nonappropriated Fund
Disability Application

EBB Form 766-R

CONTROL NUMBER: GAC 3730

EMPLOYER: The form should be given to the employee with instructions to mail it when completed by the claimant and the Attending Physician to the U.S. Army Employee Benefits Branch, P.O. Box 107, Arlington, Virginia 22210-0107.

PART A (to be completed by Employee)

EMPLOYEE: (1) Please fill out and sign this portion of your Application for Group Life Insurance Disability Benefits and/or Retirement Disability Benefits and/or 401(k) Savings Plan Disability Benefits.(IMPORTANT) - Failure to fully answer all questions will cause delay in the claim processing. Should you need assistance in completing this form, contact your Employer. (2) When completed and signed by you, forward to your Attending Physician with instructions to Complete Part C and forward to the Employee Benefits Branch at the address above.

1. LAST NAME | **FIRST NAME** | **MI** | **SEX** | **SOCIAL SECURITY #**

2. DATE OF BIRTH | **MARRIED** | **NUMBER OF CHILDREN DEPENDENT UPON YOU FOR SUPPORT**

3. MAILING ADDRESS (No.,Street,Apt. No.,P.O. Box or Rural Route) (City) (State) (Zip Code) TELEPHONE #

4. DESCRIBE THE DUTIES OF YOUR USUAL JOB IN YOUR OWN WORDS:

JOB TITLE | **YOUR EMPLOYER**

5. DID YOUR USUAL JOB INVOLVE:

- **A. THE USE OF MACHINES,TOOLS,OR EQUIPMENT?**
- **B. TECHNICAL KNOWLEDGE OR SPECIAL SKILLS?**
- **C. ANY SUPERVISORY RESPONSIBILITIES?**
- **D. TRAVEL?**

PLEASE EXPLAIN ALL YES ANSWERS:

6. DESCRIBE THE KIND AND AMOUNT OF PHYSICAL ACTIVITY INVOLVED IN YOUR JOB DURING A TYPICAL WORK DAY (SELECT NUMBER OF HOURS IN A DAY THAT YOU PERFORM THESE ACTIONS AT WORK).

WALKING: NONE | STANDING: NONE | SITTING: NONE

LIFTING AND CARRYING (DESCRIBE WHAT WAS LIFTED,HOW HEAVY IT WAS,HOW OFTEN IT WAS LIFTED AND HOW FAR IT WAS CARRIED).

7. HOW DOES YOUR ILLNESS OR INJURY NOW PREVENT YOU FROM PERFORMING YOUR USUAL DUTIES AS DESCRIBED IN ITEMS 4,5 & 6?

8. LIST ANY SKILLS WHICH YOU MAY HAVE AS A RESULT OF PRIOR EMPLOYMENT,TRAINING OR EDUCATION,OR MILITARY SERVICE:

9. LIST LAST YEAR OF SCHOOL COMPLETED: NO EDUCATION

9 BEFORE YOU STOPPED WORKING,DID YOUR ILLNESS OR INJURY CAUSE YOU TO CHANGE:

a. YOUR JOB OR DUTIES?

b. YOUR HOURS OF WORK?

c. YOUR ATTENDANCE?

(EXPLAIN HOW YOUR CONDITION CAUSED THESE CHANGES AND SHOW THE DATES THE CHANGES WERE MADE.)

10. BRIEFLY DESCRIBE YOUR INJURY OR ILLNESS THAT PREVENTS,OR HAS PREVENTED YOU FROM WORKING:

11. IF CONDITION DUE TO INJURY,PLEASE INDICATE THE FOLLOWING:

DATE OF INJURY

WHERE DID IT OCCUR?

12. DESCRIBE HOW ACCIDENT OCCURRED:

13. WHAT WAS YOUR LAST DAY OF WORK BECAUSE OF THIS DISABILI

ARE YOU STILL DISABLED?

14. IF YOU ARE NO LONGER DISABLED,ENTER DATE YOU WERE AGAIN TO WORK (MONTH,DAY,YEAR)

DATE OF FIRST TREATMENT FOR THIS ILLNESS OR INJURY

15. LIST THE NAME,ADDRESS AND TELEPHONE NUMBER OF THE DOCTOR WHO HAS YOUR LATEST MEDICAL RECORDS.

IF YOU HAVE NO DOCTOR,CHECK HERE

NAME

ADDRESS

16. HOW OFTEN DO YOU SEE THIS DOCTOR

DATE OF FIRST VISIT

DATE OF LAST VISIT

17. REASONS FOR VISITS

TYPE OF TREATMENT RECEIVED:

18 HAVE YOU SEEN ANY OTHER DOCTOR SINCE YOUR ILLNESS OR INJURY BEGAN?

IF YES, SHOW THE FOLLOWING:

NAME

ADDRESS

19 HOW OFTEN DO YOU SEE THIS DOCTOR

DATE OF FIRST VISIT

DATE OF LAST VISIT

20. REASONS FOR VISITS

TYPE OF TREATMENT RECEIVED:

21. HAS YOUR DOCTOR TOLD YOU TO RESTRICT YOUR ACTIVITIES IN ANY WAY?

IF YES, GIVE NAME OF DOCTOR AND STATE WHAT HE/SHE TOLD YOU ABOUT RESTRICTING YOUR ACTIVITIES

22. CHECK ANY OF THE FOLLOWING WHICH APPLY TO YOU:

CONFINED IN A HOSPITAL OR OTHER MEDICAL INSTITUTION.
CONFINED TO A BED OR WHEEL CHAIR AT HOME.
NONE OF THE ABOVE BUT UNABLE TO GO OUTSIDE.
ABLE TO GO OUTSIDE ONLY WITH HELP OF ANOTHER PERSON OR DEVICE.
ABLE TO GO OUTSIDE WITHOUT HELP.

23. ARE YOUR HOME DUTIES,SOCIAL ACTIVITIES OR ABILITY TO CARE FOR YOUR PERSONAL NEEDS LIMITED IN ANY WAY?
IF YES, DESCRIBE HOW AND WHY THEY ARE LIMITED.

24. DO YOU EXPECT TO RETURN TO WORK? | DATE EXPECTED TO RETURN | DATE RETURNED

25. HAVE YOU BEEN SEEN BY OTHER AGENCIES FOR YOUR INJURY OR ILNESS (VA,VOCATIONAL,REHABILITATION, WELFARE,ETC.)?
IF YES, SHOW THE FOLLOWING:

NAME OF AGENCY
ADRESS OF AGENCY
YOUR CLAIM NO. | DATES OF VISITS | TYPE OF TREATMENT OR EXAMINATION RECEIVED

26. HAVE YOU EVER FILED (OR DO YOU INTEND TO FILE) CLAIMS FOR DISABILITY BENEFITS UNDER ANY:
WORKERS COMPENSATION LAW OR PLAN?
SOCIAL SECURITY?

27. HAS THERE BEEN ANY DECISION OR ANY PAYMENT (TEMPORARY,PERMANENT,OR LUMP SUM) MADE ON THE CLAIMS FILED?

WORKERS COMPENSATION CLAIM #

28 ARE YOU ENTITLED TO DISABILITY BENEFITS FROM WORKERS COMPENSATION BECAUSE OF THIS DISABILITY:

SOURCES	IDENTIFY INSURANCE OR AGENCY	BENEFIT AMOUNT	HOW PAYABLE FROM	THRU
Workers Compensation	ALEXIS	$		

AUTHORIZATION

The above answers are true and complete according to the best of my knowledge and belief. I authorize any employer, insurance company,medical prepayment plan,service organization,physician,practioner or other person;any hospital including the Veterans Administration,or other institution to release to or obtain from the US Army Nonappropr Benefits Branch,any medical or benefit payment information that may be required to establish the validity of this claim,a said company,person or organization,to disclose any personal or claim information required for medical case study or review. A photostat of this authorization shall be as valid as the original.

EMPLOYEES SIGNATURE_ DATE_

YOU MUST NOTIFY THE EMPLOYEE BENEFITS BRANCH PROMPTLY IF:

a. Your medical condition improves so that you would be able to work,even though you have not yet returned to wor
b. You go to work whether as an employee or as a self-employed person.

EBB Form 766-R (APR 2000)

ATTENDING PHYSICIANS STATEMENT

REPLY TO:
US ARMY NAF EMPLOYEE BENEFITS BRANCH
P.O. BOX 107
ARLINGTON,VA 22210-0107

PATIENTS NAME _____ POLICYHOLDER NAME _____

DATE OF BIRTH_ _____ CONTROL NUMBER: GAC 3730

The purpose of this report is to assist us in making a disability determination. In filing out this report please include insufficient details of history, physical and diagnostic findings, clinical course, therapy and response to enable us to make this determination. After signing this form, return it to the address noted above.

1. HISTORY

(a) Patients Age.....

(b) When did symptoms first appear or accident happen

(c) Date patient ceased work because of disability.....

(d) Has patient ever had same or similar condition?.....

if "Yes" state when and describe.....

2. DIAGNOSIS (including any complications)

(a) Subjective symptoms.....

(b) Objective findings.....

(including current signs,laboratory data & x-ray results)

3. DATES OF TREATMENT

(a) Date of first visit.....

(b) Date of last visit.....

(c) Frequency.....

4. NATURE OF TREATMENT (Including Surgery,if any)

5. PROGRESS

(a) Check one..... Recovered ☐ Improved ☐ Unchanges ☐ Retrogressed ☐

(b) Is patient..... Ambulatory?

Bed confined?

(c) If hospital confined..... Name of hospital

Confined from through

6. PHYSICAL IMPAIRMENT (AS IT RELATES TO EMPLOYMENT)

☐ **Class 1 - No limitation of functional capacity;capable of heavy physical activity. No restrictions. (0-10%)**

☐ **Class 2 - Slight limitation of functional capapcity;capable of light manual activity. (15-30%)**

☐ **Class 3 - Moderate limitation of functional capacity;capable of clerical/administrative (sedentary) activity (35-55%)**

☐ **Class 4 - Marked limitation. (60-70%)**

☐ **Class 5 - Severe limitation of functional capacity;incapable of minimal (sedentary) activity. (75-100%)**

☐ **Remarks:**

EBB Form 766-R(APR 2000)

5. COMPETENCY

Is the patient competent to endorse checks and direct the use of the proceeds thereof?

6. PROGNOSIS

(a) Do you expect a fundamental or marked change in the future? **No** **Yes-Improvement** **Yes-Deterioration**

	HIS JOB	OTHER WORK
(b) if improved,will patient recover sufficiently to perform duties of	**No** / **Yes**	**No** / **Yes**
3-6 mos		
6-12 mos		
over l yr		

(c) If no improvement expected,please explain

7. REHABILITATION

	HIS JOB	OTHER WORK
(a) Is patient a suitable candidate for trial employment or job training?	**Yes** **No**	**Yes** **No**
(b) If yes,when could he commence trial employment?	**full time** **part-time**	**full time** **part-time**
	mos. day year	**mos. day year**

(c) If no,please explain_

8 REMARKS

Date	**Name (Attending Physician) Print**	**Degree**	**Telephone**

Street Address	**City or Town**	**State or Province**	**Zip Code**

Signature

EBB Form 766-R (APR 2000)

Appendix A-7

Army NAF Retiree Optional Life Insurance Continuation Form

Retiree pays premium until age 65 then coverage is free. Must have participated in the Army NAF optional insurance plan for 5 years immediately preceding retirement and elect an immediate, early or disability annuity.

Retiree Name _____
Last First MI

Retiree Date of Birth _____ Security # Date of Separation _____
Day Month Year Day Month Year

Retiree Mailing Address:

_____

_____

_____

Date Optional Insurance Elected: _____

Current Optional Insurance Amount $ _____

Lowest amount Optional Insurance in effect for the 5 year period immediately preceding retirement. $ _____

Type of retirement annuity elected: _____
(Normal, Early, Disability, Deferred)

I understand that I must meet the following requirements for eligibility and premium payments:

- I must have been a participant in the AMLF optional life insurance plan for the five year period immediately preceding my retirement
- I have elected either an immediate normal, early or disability annuity
- The maximum amount of optional insurance for which I am eligible to purchase, is the lowest amount of optional insurance in effect during the 5 year participation period immediately preceding my retirement.
- I must pay the full premium due for each month after my retirement until I have attained age 65 at age 65, this optional insurance coverage will be provided to me free of charge and it will reduce at a rate of two percent per month from age 65, for fifty months until this coverage ends.
- Premiums are due quarterly, before the quarter begins. The quarterly amount due changes every 4 years and is based on the age of the retiree. Premium amounts due are listed below and may be subject to change on an annual basis. I will be notified if the premium amount due changes. Monthly premium amounts may be paid upon enrolling in the life insurance plan, until I reach a quarterly cycle of January 1st, April 1st, July 1st, October 1st at which time, quarterly payments must be made. I will NOT receive a bill or statement. Payment is the retiree's full responsibility.
- It is my responsibility to continue premium payments based on the chart shown on the next page. If I fail to continue premium payments in accordance with the premium amounts due prior to each quarter, my coverage will terminate and it will not be reinstated.

_____ _____
Signature of Retiree Date

Mail this form and first quarter premium check **made payable to the AMLF** to:
Employee Benefits Office,P.O. Box 107,Arlington,VA 22210-1017

Applications and checks received 60 days after retirement will be returned and continuation of optional life insurance coverage will not be permitted.

Quarterly Cost Optional Insurance

	AGE OF EMPLOYEE/RETIREE								
OPT AMT	UNDER 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 and Over
$10k	$ 3.90	$ 4.55	$ 7.80	$ 11.70	$ 19.50	$ 29.90	$ 49.40	$ 68.90	$ 110.50
$20K	$ 7.80	$ 9.10	$ 15.60	$ 23.40	$ 39.00	$ 59.80	$ 98.80	$ 137.80	$ 221.00
$30K	$ 11.70	$ 13.65	$ 23.40	$ 35.10	$ 58.50	$ 89.70	$ 148.20	$ 206.70	$ 331.50
$40K	$ 15.60	$ 18.20	$ 31.20	$ 46.80	$ 78.00	$ 119.60	$ 197.60	$ 275.60	$ 442.00
$50K	$ 19.50	$ 22.75	$ 39.00	$ 58.50	$ 97.50	$ 149.50	$ 247.00	$ 344.50	$ 552.50
$60K	$ 23.40	$ 27.30	$ 46.80	$ 70.20	$ 117.00	$ 179.40	$ 296.40	$ 413.40	$ 663.00
$70K	$ 27.30	$ 31.85	$ 54.60	$ 81.90	$ 136.50	$ 209.30	$ 345.80	$ 482.30	$ 773.50
$80K	$ 31.20	$ 36.40	$ 62.40	$ 93.60	$ 156.00	$ 239.20	$ 395.20	$ 551.20	$ 884.00
$90K	$ 35.10	$ 40.95	$ 70.20	$ 105.30	$ 175.50	$ 269.10	$ 444.60	$ 620.10	$ 994.50
$100K	$ 39.00	$ 45.50	$ 78.00	$ 117.00	$ 195.00	$ 299.00	$ 494.00	$ 689.00	$ 1,105.00
$110K	$42.90	$50.05	$85.80	$128.70	$214.50	$328.90	$543.40	$757.90	$1,215.50
$120K	$ 46.80	$ 54.60	$ 93.60	$ 140.40	$ 234.00	$ 358.80	$ 592.80	$ 826.80	$ 1,326.00
$130K	$ 50.70	$ 59.15	$ 101.40	$ 152.10	$ 253.50	$ 388.70	$ 642.20	$ 895.70	$ 1,436.50
$140K	$ 54.60	$ 63.70	$ 109.20	$ 163.80	$ 273.00	$ 418.60	$ 691.60	$ 964.60	$ 1,547.00
$150K	$ 58.50	$ 68.25	$ 117.00	$ 175.50	$ 292.50	$ 448.50	$ 741.00	$ 1,033.50	$ 1,657.50
$160K	$ 62.40	$ 72.80	$ 124.80	$ 187.20	$ 312.00	$ 478.40	$ 790.40	$ 1,102.40	$ 1,768.00
$170K	$ 66.30	$ 77.35	$ 132.60	$ 198.90	$ 331.50	$ 508.30	$ 839.80	$ 1,171.30	$ 1,878.50
$180K	$ 70.20	$ 81.90	$ 140.40	$ 210.60	$ 351.00	$ 538.20	$ 889.20	$ 1,240.20	$ 1,989.00
$190K	$ 74.10	$ 86.45	$ 148.20	$ 222.30	$ 370.50	$ 568.10	$ 938.60	$ 1,309.10	$ 2,099.50
$200K	$ 78.00	$ 91.00	$ 156.00	$ 234.00	$ 390.00	$ 598.00	$ 988.00	$ 1,378.00	$ 2,210.00
$220K	$ 81.90	$ 95.55	$ 163.80	$ 245.70	$ 409.50	$ 627.90	$ 1,037.40	$ 1,446.90	$ 2,320.50
$230K	$ 85.80	$ 100.10	$ 171.60	$ 257.40	$ 429.00	$ 657.80	$ 1,086.80	$ 1,515.80	$ 2,431.00
$240K	$ 89.70	$ 104.65	$ 179.40	$ 269.10	$ 448.50	$ 687.70	$ 1,136.20	$ 1,584.70	$ 2,541.50
$250K	$ 93.60	$ 109.20	$ 187.20	$ 280.80	$ 468.00	$ 717.60	$ 1,185.60	$ 1,653.60	$ 2,652.00
$260K	$ 97.50	$ 113.75	$ 195.00	$ 292.50	$ 487.50	$ 747.50	$ 1,235.00	$ 1,722.50	$ 2,762.50
$270K	$ 101.40	$ 118.30	$ 202.80	$ 304.20	$ 507.00	$ 777.40	$ 1,284.40	$ 1,791.40	$ 2,873.00
$280K	$ 105.30	$ 122.85	$ 210.60	$ 315.90	$ 526.50	$ 807.30	$ 1,333.80	$ 1,860.30	$ 2,983.50
$290K	$ 109.20	$ 127.40	$ 218.40	$ 327.60	$ 546.00	$ 837.20	$ 1,383.20	$ 1,929.20	$ 3,094.00
$300K	$ 113.10	$ 131.95	$ 226.20	$ 339.30	$ 565.50	$ 867.10	$ 1,432.60	$ 1,998.10	$ 3,204.50
$310K	$ 117.00	$ 136.50	$ 234.00	$ 351.00	$ 585.00	$ 897.00	$ 1,482.00	$ 2,067.00	$ 3,315.00
$320K	$ 120.90	$ 141.05	$ 241.80	$ 362.70	$ 604.50	$ 926.90	$ 1,531.40	$ 2,135.90	$ 3,425.50
$330K	$ 124.80	$ 145.60	$ 249.60	$ 374.40	$ 624.00	$ 956.80	$ 1,580.80	$ 2,204.80	$ 3,536.00
$340K	$ 128.70	$ 150.15	$ 257.40	$ 386.10	$ 643.50	$ 986.70	$ 1,630.20	$ 2,273.70	$ 3,646.50
$350K	$ 132.60	$ 154.70	$ 265.20	$ 397.80	$ 663.00	$ 1,016.60	$ 1,679.60	$ 2,342.60	$ 3,757.00
$360K	$ 136.50	$ 159.25	$ 273.00	$ 409.50	$ 682.50	$ 1,046.50	$ 1,729.00	$ 2,411.50	$ 3,867.50
$370K	$ 140.40	$ 163.80	$ 280.80	$ 421.20	$ 702.00	$ 1,076.40	$ 1,778.40	$ 2,480.40	$ 3,978.00
$380K	$ 144.30	$ 168.35	$ 288.60	$ 432.90	$ 721.50	$ 1,106.30	$ 1,827.80	$ 2,549.30	$ 4,088.50
$390K	$ 148.20	$ 172.90	$ 296.40	$ 444.60	$ 741.00	$ 1,136.20	$ 1,877.20	$ 2,618.20	$ 4,199.00
$400K	$ 152.10	$ 177.45	$ 304.20	$ 456.30	$ 760.50	$ 1,166.10	$ 1,926.60	$ 2,687.10	$ 4,309.50
$410K	$ 156.00	$ 182.00	$ 312.00	$ 468.00	$ 780.00	$ 1,196.00	$ 1,976.00	$ 2,756.00	$ 4,420.00
$420K	$ 159.90	$ 186.55	$ 319.80	$ 479.70	$ 799.50	$ 1,225.90	$ 2,025.40	$ 2,824.90	$ 4,530.50
$430K	$ 163.80	$ 191.10	$ 327.60	$ 491.40	$ 819.00	$ 1,255.80	$ 2,074.80	$ 2,893.80	$ 4,641.00
$440K	$ 167.70	$ 195.65	$ 335.40	$ 503.10	$ 838.50	$ 1,285.70	$ 2,124.20	$ 2,962.70	$ 4,751.50
$450K	$ 171.60	$ 200.20	$ 343.20	$ 514.80	$ 858.00	$ 1,315.60	$ 2,173.60	$ 3,031.60	$ 4,862.00
$460K	$ 175.50	$ 204.75	$ 351.00	$ 526.50	$ 877.50	$ 1,345.50	$ 2,223.00	$ 3,100.50	$ 4,972.50
$470K	$ 179.40	$ 209.30	$ 358.80	$ 538.20	$ 897.00	$ 1,375.40	$ 2,272.40	$ 3,169.40	$ 5,083.00
$480K	$ 183.30	$ 213.85	$ 366.60	$ 549.90	$ 916.50	$ 1,405.30	$ 2,321.80	$ 3,238.30	$ 5,193.50
$490K	$ 187.20	$ 218.40	$ 374.40	$ 561.60	$ 936.00	$ 1,435.20	$ 2,371.20	$ 3,307.20	$ 5,304.00
$500K	$ 191.10	$ 222.95	$ 382.20	$ 573.30	$ 955.50	$ 1,465.10	$ 2,420.60	$ 3,376.10	$ 5,414.50

Monthly Cost Optional Insurance

AGE EMPLOYEERETIREE

OPT AMT	UNDER 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 and Over
$10k	$ 1.30	$ 1.52	$ 2.60	$ 3.90	$ 6.50	$ 9.97	$ 16.47	$ 22.97	$ 36.83
$20K	$ 2.60	$ 3.03	$ 5.20	$ 7.80	$ 13.00	$ 19.93	$ 32.93	$ 45.93	$ 73.67
$30K	$ 3.90	$ 4.55	$ 7.80	$ 11.70	$ 19.50	$ 29.90	$ 49.40	$ 68.90	$ 110.50
$40K	$ 5.20	$ 6.07	$ 10.40	$ 15.60	$ 26.00	$ 39.87	$ 65.87	$ 91.87	$ 147.33
$50K	$ 6.50	$ 7.58	$ 13.00	$ 19.50	$ 32.50	$ 49.83	$ 82.33	$ 114.83	$ 184.17
$60K	$ 7.80	$ 9.10	$ 15.60	$ 23.40	$ 39.00	$ 59.80	$ 98.80	$ 137.80	$ 221.00
$70K	$ 9.10	$ 10.62	$ 18.20	$ 27.30	$ 45.50	$ 69.77	$ 115.27	$ 160.77	$ 257.83
$80K	$ 10.40	$ 12.13	$ 20.80	$ 31.20	$ 52.00	$ 79.73	$ 131.73	$ 183.73	$ 294.67
$90K	$ 11.70	$ 13.65	$ 23.40	$ 35.10	$ 58.50	$ 89.70	$ 148.20	$ 206.70	$ 331.50
$100K	$ 13.00	$ 15.17	$ 26.00	$ 39.00	$ 65.00	$ 99.67	$ 164.67	$ 229.67	$ 368.33
$110K	$14.30	$16.68	$28.60	$42.90	$71.50	$109.63	$181.13	$252.63	$405.17
$120K	$ 15.60	$ 18.20	$ 31.20	$ 46.80	$ 78.00	$ 119.60	$ 197.60	$ 275.60	$ 442.00
$130K	$ 16.90	$ 19.72	$ 33.80	$ 50.70	$ 84.50	$ 129.57	$ 214.07	$ 298.57	$ 478.83
$140K	$ 18.20	$ 21.23	$ 36.40	$ 54.60	$ 91.00	$ 139.53	$ 230.53	$ 321.53	$ 515.67
$150K	$ 19.50	$ 22.75	$ 39.00	$ 58.50	$ 97.50	$ 149.50	$ 247.00	$ 344.50	$ 552.50
$160K	$ 20.80	$ 24.27	$ 41.60	$ 62.40	$ 104.00	$ 159.47	$ 263.47	$ 367.47	$ 589.33
$170K	$ 22.10	$ 25.78	$ 44.20	$ 66.30	$ 110.50	$ 169.43	$ 279.93	$ 390.43	$ 626.17
$180K	$ 23.40	$ 27.30	$ 46.80	$ 70.20	$ 117.00	$ 179.40	$ 296.40	$ 413.40	$ 663.00
$190K	$ 24.70	$ 28.82	$ 49.40	$ 74.10	$ 123.50	$ 189.37	$ 312.87	$ 436.37	$ 699.83
$200K	$ 26.00	$ 30.33	$ 52.00	$ 78.00	$ 130.00	$ 199.33	$ 329.33	$ 459.33	$ 736.67
$220K	$ 27.30	$ 31.85	$ 54.60	$ 81.90	$ 136.50	$ 209.30	$ 345.80	$ 482.30	$ 773.50
$230K	$ 28.60	$ 33.37	$ 57.20	$ 85.80	$ 143.00	$ 219.27	$ 362.27	$ 505.27	$ 810.33
$240K	$ 29.90	$ 34.88	$ 59.80	$ 89.70	$ 149.50	$ 229.23	$ 378.73	$ 528.23	$ 847.17
$250K	$ 31.20	$ 36.40	$ 62.40	$ 93.60	$ 156.00	$ 239.20	$ 395.20	$ 551.20	$ 884.00
$260K	$ 32.50	$ 37.92	$ 65.00	$ 97.50	$ 162.50	$ 249.17	$ 411.67	$ 574.17	$ 920.83
$270K	$ 33.80	$ 39.43	$ 67.60	$ 101.40	$ 169.00	$ 259.13	$ 428.13	$ 597.13	$ 957.67
$280K	$ 35.10	$ 40.95	$ 70.20	$ 105.30	$ 175.50	$ 269.10	$ 444.60	$ 620.10	$ 994.50
$290K	$ 36.40	$ 42.47	$ 72.80	$ 109.20	$ 182.00	$ 279.07	$ 461.07	$ 643.07	$ 1,031.33
$300K	$ 37.70	$ 43.98	$ 75.40	$ 113.10	$ 188.50	$ 289.03	$ 477.53	$ 666.03	$ 1,068.17
$310K	$ 39.00	$ 45.50	$ 78.00	$ 117.00	$ 195.00	$ 299.00	$ 494.00	$ 689.00	$ 1,105.00
$320K	$ 40.30	$ 47.02	$ 80.60	$ 120.90	$ 201.50	$ 308.97	$ 510.47	$ 711.97	$ 1,141.83
$330K	$ 41.60	$ 48.53	$ 83.20	$ 124.80	$ 208.00	$ 318.93	$ 526.93	$ 734.93	$ 1,178.67
$340K	$ 42.90	$ 50.05	$ 85.80	$ 128.70	$ 214.50	$ 328.90	$ 543.40	$ 757.90	$ 1,215.50
$350K	$ 44.20	$ 51.57	$ 88.40	$ 132.60	$ 221.00	$ 338.87	$ 559.87	$ 780.87	$ 1,252.33
$360K	$ 45.50	$ 53.08	$ 91.00	$ 136.50	$ 227.50	$ 348.83	$ 576.33	$ 803.83	$ 1,289.17
$370K	$ 46.80	$ 54.60	$ 93.60	$ 140.40	$ 234.00	$ 358.80	$ 592.80	$ 826.80	$ 1,326.00
$380K	$ 48.10	$ 56.12	$ 96.20	$ 144.30	$ 240.50	$ 368.77	$ 609.27	$ 849.77	$ 1,362.83
$390K	$ 49.40	$ 57.63	$ 98.80	$ 148.20	$ 247.00	$ 378.73	$ 625.73	$ 872.73	$ 1,399.67
$400K	$ 50.70	$ 59.15	$ 101.40	$ 152.10	$ 253.50	$ 388.70	$ 642.20	$ 895.70	$ 1,436.50
$410K	$ 52.00	$ 60.67	$ 104.00	$ 156.00	$ 260.00	$ 398.67	$ 658.67	$ 918.67	$ 1,473.33
$420K	$ 53.30	$ 62.18	$ 106.60	$ 159.90	$ 266.50	$ 408.63	$ 675.13	$ 941.63	$ 1,510.17
$430K	$ 54.60	$ 63.70	$ 109.20	$ 163.80	$ 273.00	$ 418.60	$ 691.60	$ 964.60	$ 1,547.00
$440K	$ 55.90	$ 65.22	$ 111.80	$ 167.70	$ 279.50	$ 428.57	$ 708.07	$ 987.57	$ 1,583.83
$450K	$ 57.20	$ 66.73	$ 114.40	$ 171.60	$ 286.00	$ 438.53	$ 724.53	$ 1,010.53	$ 1,620.67
$460K	$ 58.50	$ 68.25	$ 117.00	$ 175.50	$ 292.50	$ 448.50	$ 741.00	$ 1,033.50	$ 1,657.50
$470K	$ 59.80	$ 69.77	$ 119.60	$ 179.40	$ 299.00	$ 458.47	$ 757.47	$ 1,056.47	$ 1,694.33
$480K	$ 61.10	$ 71.28	$ 122.20	$ 183.30	$ 305.50	$ 468.43	$ 773.93	$ 1,079.43	$ 1,731.17
$490K	$ 62.40	$ 72.80	$ 124.80	$ 187.20	$ 312.00	$ 478.40	$ 790.40	$ 1,102.40	$ 1,768.00
$500K	$ 63.70	$ 74.32	$ 127.40	$ 191.10	$ 318.50	$ 488.37	$ 806.87	$ 1,125.37	$ 1,804.83

Biweekly Cost Optional Insurance

	AGE EMPLOYEE/RETIREE								
OPT AMT	UNDER 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 and Over
$10k	$ 0.60	$ 0.70	$ 1.20	$ 1.80	$ 3.00	$ 4.60	$ 7.60	$ 10.60	$ 17.00
$20K	$ 1.20	$ 1.40	$ 2.40	$ 3.60	$ 6.00	$ 9.20	$ 15.20	$ 21.20	$ 34.00
$30K	$ 1.80	$ 2.10	$ 3.60	$ 5.40	$ 9.00	$ 13.80	$ 22.80	$ 31.80	$ 51.00
$40K	$ 2.40	$ 2.80	$ 4.80	$ 7.20	$ 12.00	$ 18.40	$ 30.40	$ 42.40	$ 68.00
$50K	$ 3.00	$ 3.50	$ 6.00	$ 9.00	$ 15.00	$ 23.00	$ 38.00	$ 53.00	$ 85.00
$60K	$ 3.60	$ 4.20	$ 7.20	$ 10.80	$ 18.00	$ 27.60	$ 45.60	$ 63.60	$ 102.00
$70K	$ 4.20	$ 4.90	$ 8.40	$ 12.60	$ 21.00	$ 32.20	$ 53.20	$ 74.20	$ 119.00
$80K	$ 4.80	$ 5.60	$ 9.60	$ 14.40	$ 24.00	$ 36.80	$ 60.80	$ 84.80	$ 136.00
$90K	$ 5.40	$ 6.30	$ 10.80	$ 16.20	$ 27.00	$ 41.40	$ 68.40	$ 95.40	$ 153.00
$100K	$ 6.00	$ 7.00	$ 12.00	$ 18.00	$ 30.00	$ 46.00	$ 76.00	$ 106.00	$ 170.00
$110K	$6.60	$7.70	$13.20	$19.80	$33.00	$50.60	$83.60	$116.60	$187.00
$120K	$ 7.20	$ 8.40	$ 14.40	$ 21.60	$ 36.00	$ 55.20	$ 91.20	$ 127.20	$ 204.00
$130K	$ 7.80	$ 9.10	$ 15.60	$ 23.40	$ 39.00	$ 59.80	$ 98.80	$ 137.80	$ 221.00
$140K	$ 8.40	$ 9.80	$ 16.80	$ 25.20	$ 42.00	$ 64.40	$ 106.40	$ 148.40	$ 238.00
$150K	$ 9.00	$ 10.50	$ 18.00	$ 27.00	$ 45.00	$ 69.00	$ 114.00	$ 159.00	$ 255.00
$160K	$ 9.60	$ 11.20	$ 19.20	$ 28.80	$ 48.00	$ 73.60	$ 121.60	$ 169.60	$ 272.00
$170K	$ 10.20	$ 11.90	$ 20.40	$ 30.60	$ 51.00	$ 78.20	$ 129.20	$ 180.20	$ 289.00
$180K	$ 10.80	$ 12.60	$ 21.60	$ 32.40	$ 54.00	$ 82.80	$ 136.80	$ 190.80	$ 306.00
$190K	$ 11.40	$ 13.30	$ 22.80	$ 34.20	$ 57.00	$ 87.40	$ 144.40	$ 201.40	$ 323.00
$200K	$ 12.00	$ 14.00	$ 24.00	$ 36.00	$ 60.00	$ 92.00	$ 152.00	$ 212.00	$ 340.00
$220K	$ 12.60	$ 14.70	$ 25.20	$ 37.80	$ 63.00	$ 96.60	$ 159.60	$ 222.60	$ 357.00
$230K	$ 13.20	$ 15.40	$ 26.40	$ 39.60	$ 66.00	$ 101.20	$ 167.20	$ 233.20	$ 374.00
$240K	$ 13.80	$ 16.10	$ 27.60	$ 41.40	$ 69.00	$ 105.80	$ 174.80	$ 243.80	$ 391.00
$250K	$ 14.40	$ 16.80	$ 28.80	$ 43.20	$ 72.00	$ 110.40	$ 182.40	$ 254.40	$ 408.00
$260K	$ 15.00	$ 17.50	$ 30.00	$ 45.00	$ 75.00	$ 115.00	$ 190.00	$ 265.00	$ 425.00
$270K	$ 15.60	$ 18.20	$ 31.20	$ 46.80	$ 78.00	$ 119.60	$ 197.60	$ 275.60	$ 442.00
$280K	$ 16.20	$ 18.90	$ 32.40	$ 48.60	$ 81.00	$ 124.20	$ 205.20	$ 286.20	$ 459.00
$290K	$ 16.80	$ 19.60	$ 33.60	$ 50.40	$ 84.00	$ 128.80	$ 212.80	$ 296.80	$ 476.00
$300K	$ 17.40	$ 20.30	$ 34.80	$ 52.20	$ 87.00	$ 133.40	$ 220.40	$ 307.40	$ 493.00
$310K	$ 18.00	$ 21.00	$ 36.00	$ 54.00	$ 90.00	$ 138.00	$ 228.00	$ 318.00	$ 510.00
$320K	$ 18.60	$ 21.70	$ 37.20	$ 55.80	$ 93.00	$ 142.60	$ 235.60	$ 328.60	$ 527.00
$330K	$ 19.20	$ 22.40	$ 38.40	$ 57.60	$ 96.00	$ 147.20	$ 243.20	$ 339.20	$ 544.00
$340K	$ 19.80	$ 23.10	$ 39.60	$ 59.40	$ 99.00	$ 151.80	$ 250.80	$ 349.80	$ 561.00
$350K	$ 20.40	$ 23.80	$ 40.80	$ 61.20	$ 102.00	$ 156.40	$ 258.40	$ 360.40	$ 578.00
$360K	$ 21.00	$ 24.50	$ 42.00	$ 63.00	$ 105.00	$ 161.00	$ 266.00	$ 371.00	$ 595.00
$370K	$ 21.60	$ 25.20	$ 43.20	$ 64.80	$ 108.00	$ 165.60	$ 273.60	$ 381.60	$ 612.00
$380K	$ 22.20	$ 25.90	$ 44.40	$ 66.60	$ 111.00	$ 170.20	$ 281.20	$ 392.20	$ 629.00
$390K	$ 22.80	$ 26.60	$ 45.60	$ 68.40	$ 114.00	$ 174.80	$ 288.80	$ 402.80	$ 646.00
$400K	$ 23.40	$ 27.30	$ 46.80	$ 70.20	$ 117.00	$ 179.40	$ 296.40	$ 413.40	$ 663.00
$410K	$ 24.00	$ 28.00	$ 48.00	$ 72.00	$ 120.00	$ 184.00	$ 304.00	$ 424.00	$ 680.00
$420K	$ 24.60	$ 28.70	$ 49.20	$ 73.80	$ 123.00	$ 188.60	$ 311.60	$ 434.60	$ 697.00
$430K	$ 25.20	$ 29.40	$ 50.40	$ 75.60	$ 126.00	$ 193.20	$ 319.20	$ 445.20	$ 714.00
$440K	$ 25.80	$ 30.10	$ 51.60	$ 77.40	$ 129.00	$ 197.80	$ 326.80	$ 455.80	$ 731.00
$450K	$ 26.40	$ 30.80	$ 52.80	$ 79.20	$ 132.00	$ 202.40	$ 334.40	$ 466.40	$ 748.00
$460K	$ 27.00	$ 31.50	$ 54.00	$ 81.00	$ 135.00	$ 207.00	$ 342.00	$ 477.00	$ 765.00
$470K	$ 27.60	$ 32.20	$ 55.20	$ 82.80	$ 138.00	$ 211.60	$ 349.60	$ 487.60	$ 782.00
$480K	$ 28.20	$ 32.90	$ 56.40	$ 84.60	$ 141.00	$ 216.20	$ 357.20	$ 498.20	$ 799.00
$490K	$ 28.80	$ 33.60	$ 57.60	$ 86.40	$ 144.00	$ 220.80	$ 364.80	$ 508.80	$ 816.00
$500K	$ 29.40	$ 34.30	$ 58.80	$ 88.20	$ 147.00	$ 225.40	$ 372.40	$ 519.40	$ 833.00